AMENDED IN ASSEMBLY SEPTEMBER 8, 2011

AMENDED IN ASSEMBLY SEPTEMBER 7, 2011

AMENDED IN ASSEMBLY AUGUST 30, 2011

AMENDED IN SENATE MAY 31, 2011

AMENDED IN SENATE MAY 3, 2011

AMENDED IN SENATE APRIL 11, 2011

AMENDED IN SENATE MARCH 24, 2011

SENATE BILL No. 923

Introduced by Senator De León

February 18, 2011

An act to amend Section 5307.1 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 923, as amended, De León. Workers' compensation: official medical fee schedule: physician services.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law requires the administrative director, after public hearings, to adopt and revise periodically an official medical fee schedule that establishes reasonable maximum fees paid for medical services, other than physician services, and other prescribed goods and services in accordance with specified requirements.

Existing law, notwithstanding the above provisions, further authorizes the administrative director, after public hearings, to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services, in accordance with specified requirements.

This bill would instead require the administrative director, by January 1, 2013, to adopt an official medical fee schedule for physician services based on the resource-based relative value scale, as defined, would authorize the administrative director no less frequently than biennially, to revise the official medical fee schedule for physician services, and would delete obsolete provisions relating to the adoption of a medical fee schedule for inpatient facility fees for burn cases. This bill would require the initial resource-based relative value scale official medical fee schedule to use a conversion factor or set of factors that is determined by the administrative director, as prescribed, to result in no overall increased costs to the workers' compensation system.

This bill would incorporate additional changes in Section 5307.1 of the Labor Code proposed by AB 378, that would become operative only if AB 378 and this bill are both chaptered and become effective on or before January 1, 2012, and this bill is chaptered last.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known and may be cited as the Fair Fee Schedule for Workers' Compensation Physicians Act.

SEC. 2. The Legislature finds and declares all of the following:

(a) The amount payers are required to pay to physicians providing primary care to injured workers in California is wholly dependent on the statewide official medical fee schedule for physician services as determined from time to time by the Administrative Director of the Division of Workers' Compensation.

(b) California's official medical fee schedule for primary care workers' compensation physician services is currently the second lowest in the nation, even while California providers have the highest cost of providing medical services to injured workers. The current reimbursement rates for workers' compensation physicians in California are nearly 50 percent lower than those in the nearby states of Oregon and Washington.

(c) California's primary care workers' compensation physicians have not had a meaningful fee schedule increase in over 11 years, while the California Consumer Price Index has increased 33 percent over that period. This has resulted in a steady decrease in real income for the state's primary care workers' compensation physicians.

(d) This inequity is causing physicians to abandon the practice of primary care occupational medicine, resulting in diminished access to low-cost, high-quality care for California's injured workers. Without fee schedule relief, primary care workers' compensation physicians will continue to leave the occupational medicine practice, resulting in increased use of far more costly alternatives, including, but not limited to, hospital emergency rooms, and increased time away from work. Once primary care providers leave the occupational medicine practice, the damage to California's workers' compensation system will be irreparable.

(e) California's primary care workers' compensation physicians are the gatekeepers to the state's workers' compensation system, serving as case managers for injured workers and returning them to gainful employment as quickly as possible, thereby controlling total case costs. Without fee schedule relief, California will suffer higher total injury case costs that will result in increased insurance premiums to employers throughout California.

(f) Subdivision (*l*) of Section 5307.1 provides the Administrative Director of the Division of Workers' Compensation with authority to adopt and revise, no less frequently than biennially, an official medical fee schedule for physician services. Pursuant to this authority, the Division of Workers' Compensation has developed a new official medical fee schedule for physician services in California based on the resource-based relative value scale (RBRVS). The RBRVS is widely recognized as the best model for fair and proper allocation of resources for physician payment. It is currently used by the federal Centers for Medicare and Medicaid Services, and in 33 other states' workers' compensation physician services fee schedules.

(g) It is the intent of the Legislature to address these issues by adopting the Fair Fee Schedule for Workers' Compensation Physicians Act.

SEC. 3. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, shall not exceed 120 percent of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item. However, the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, or, with regard to pharmacy services and drugs, for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system

for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) This section does not prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components shall not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but shall not reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(*l*) (1) Notwithstanding subdivision (a), the administrative director shall, by January 1, 2013, adopt an official medical fee schedule for physician services that is based on the resource-based relative value scale. The initial resource-based relative value scale official medical fee schedule for physician services adopted under this subdivision shall use a conversion factor, or set of conversion factors, that is determined by the administrative director to result in no overall increased costs to the workers' compensation system as compared to the prior year's official medical fee schedule. The administrative director may adopt multiple conversion factors in the initial fee schedule required by this paragraph over a three-year period to account for the impact of the initial fee schedule on providers. The administrative director may, no less frequently than biennially, revise the official medical fee schedule for physician services based on the resource-based relative value scale.

(2) For purposes of this subdivision, "resource-based relative value scale" means the relative value scale created by the federal Centers for Medicare and Medicaid Services and set forth in the Federal Register for each calendar year.

SEC. 3.5. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) The administrative director, after public hearings, shall adopt and revise periodically an official medical fee schedule that shall establish reasonable maximum fees paid for medical

services other than physician services, drugs and pharmacy services, health care facility fees, home health care, and all other treatment, care, services, and goods described in Section 4600 and provided pursuant to this section. Except for physician services, all fees shall be in accordance with the fee-related structure and rules of the relevant Medicare and Medi-Cal payment systems, provided that employer liability for medical treatment, including issues of reasonableness, necessity, frequency, and duration, shall be determined in accordance with Section 4600. Commencing January 1, 2004, and continuing until the time the administrative director has adopted an official medical fee schedule in accordance with the fee-related structure and rules of the relevant Medicare payment systems, except for the components listed in subdivision (j), maximum reasonable fees shall be 120 percent of the estimated aggregate fees prescribed in the relevant Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g), except that for pharmacy services and drugs that are not otherwise covered by a Medicare fee schedule payment for facility services, the maximum reasonable fees shall be 100 percent of fees prescribed in the relevant Medi-Cal payment system. Upon adoption by the administrative director of an official medical fee schedule pursuant to this section, the maximum reasonable fees paid shall not exceed 120 percent of estimated aggregate fees prescribed in the Medicare payment system for the same class of services before application of the inflation factors provided in subdivision (g). Pharmacy services and drugs shall be subject to the requirements of this section, whether furnished through a pharmacy or dispensed directly by the practitioner pursuant to subdivision (b) of Section 4024 of the Business and Professions Code.

(b) In order to comply with the standards specified in subdivision (f), the administrative director may adopt different conversion factors, diagnostic-related group weights, and other factors affecting payment amounts from those used in the Medicare payment system, provided estimated aggregate fees do not exceed 120 percent of the estimated aggregate fees paid for the same class of services in the relevant Medicare payment system.

(c) Notwithstanding subdivisions (a) and (d), the maximum facility fee for services performed in an ambulatory surgical center, or in a hospital outpatient department, shall not exceed 120 percent

of the fee paid by Medicare for the same services performed in a hospital outpatient department.

(d) If the administrative director determines that a medical treatment, facility use, product, or service is not covered by a Medicare payment system, the administrative director shall establish maximum fees for that item, provided that the maximum fee paid shall not exceed 120 percent of the fees paid by Medicare for services that require comparable resources. If the administrative director determines that a pharmacy service or drug is not covered by a Medi-Cal payment system, the administrative director shall establish maximum fees for that item. However, the maximum fee paid shall not exceed 100 percent of the fees paid by Medi-Cal for pharmacy services or drugs that require comparable resources.

(e) (1) Prior to the adoption by the administrative director of a medical fee schedule pursuant to this section, for any treatment, facility use, product, or service not covered by a Medicare payment system, including acupuncture services, the maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003, except as otherwise provided in this subdivision.

(2) Any compounded drug product shall be billed by the compounding pharmacy or dispensing physician at the ingredient level, with each ingredient identified using the applicable National Drug Code (NDC) of the ingredient and the corresponding quantity, and in accordance with regulations adopted by the California State Board of Pharmacy. Ingredients with no NDC shall not be separately reimbursable. The ingredient-level reimbursement shall be equal to 100 percent of the reimbursement allowed by the Medi-Cal payment system and payment shall be based on the sum of the allowable fee for each ingredient plus a dispensing fee equal to the dispensing fee allowed by the Medi-Cal payment systems. If the compounded drug product is dispensed by a physician, the maximum reimbursement shall not exceed ~~the lesser of the amount otherwise allowable pursuant to this paragraph or the amount allowable pursuant to paragraph (5).~~ *300 percent of documented paid costs, but in no case more than twenty dollars ($20) above documented paid costs.*

(3) For a dangerous drug dispensed by a physician that is a finished drug product approved by the federal Food and Drug Administration, the maximum reimbursement shall be according

to the official medical fee schedule adopted by the administrative director.

(4) For a dangerous device dispensed by a physician, the reimbursement to the physician shall not exceed either of the following:

(A) The amount allowed for the device pursuant to the official medical fee schedule adopted by the administrative director.

(B) One hundred twenty percent of the documented paid cost, but not less than 100 percent of the documented paid cost plus the minimum dispensing fee allowed for dispensing prescription drugs pursuant to the official medical fee schedule adopted by the administrative director, and not more than 100 percent of the documented paid cost plus two hundred fifty dollars ($250).

(5) For any pharmacy goods dispensed by a physician not subject to paragraph ~~(3)~~ *(2), (3),* or (4), the maximum reimbursement to a physician for pharmacy goods dispensed by the physician shall not exceed any of the following:

(A) The amount allowed for the pharmacy goods pursuant to the official medical fee schedule adopted by the administrative director or pursuant to paragraph (2), as applicable.

(B) One hundred twenty percent of the documented paid cost to the physician.

(C) One hundred percent of the documented paid cost to the physician plus two hundred fifty dollars ($250).

(6) For the purposes of this subdivision, the following definitions apply:

(A) “Administer” or “administered” has the meaning defined by Section 4016 of the Business and Professions Code.

(B) “Compounded drug product” means any drug product subject to Article 4.5 (commencing with Section 1735) of Division 17 of Title 16 of the California Code of Regulations or other regulation adopted by the State Board of Pharmacy to govern the practice of compounding.

(C) “Dispensed” means furnished to or for a patient as contemplated by Section 4024 of the Business and Professions Code and does not include “administered.”

(D) “Dangerous drug” and “dangerous device” have the meanings defined by Section 4022 of the Business and Professions Code.

(E) "Documented paid cost" means the unit price paid for the specific product or for each component used in the product as documented by invoices, proof of payment, and inventory records as applicable, or as documented in accordance with regulations that may be adopted by the administrative director, net of rebates, discounts, and any other immediate or anticipated cost adjustments.

(F) "Pharmacy goods" has the same meaning as set forth in Section 139.3.

(7) To the extent that any provision of paragraphs (2) to (6), inclusive, is inconsistent with any provision of the official medical fee schedule adopted by the administrative director on or after January 1, 2012, the provision adopted by the administrative director shall govern.

(8) Notwithstanding paragraph (7), the provisions of this subdivision concerning physician-dispensed pharmacy goods shall not be superseded by any provision of the official medical fee schedule adopted by the administrative director unless the relevant official medical fee schedule provision is expressly applicable to physician-dispensed pharmacy goods.

(f) Within the limits provided by this section, the rates or fees established shall be adequate to ensure a reasonable standard of services and care for injured employees.

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule shall be adjusted to conform to any relevant changes in the Medicare and Medi-Cal payment systems no later than 60 days after the effective date of those changes, provided that both of the following conditions are met:

(i) The annual inflation adjustment for facility fees for inpatient hospital services provided by acute care hospitals and for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for the 12 months beginning October 1 of the preceding calendar year.

(ii) The annual update in the operating standardized amount and capital standard rate for inpatient hospital services provided by hospitals excluded from the Medicare prospective payment system for acute care hospitals and the conversion factor for hospital outpatient services shall be determined solely by the estimated increase in the hospital market basket for excluded hospitals for the 12 months beginning October 1 of the preceding calendar year.

(B) The update factors contained in clauses (i) and (ii) of subparagraph (A) shall be applied beginning with the first update in the Medicare fee schedule payment amounts after December 31, 2003.

(C) The maximum reasonable fees paid for pharmacy services and drugs shall not include any reductions in the relevant Medi-Cal payment system implemented pursuant to Section 14105.192 of the Welfare and Institutions Code.

(2) The administrative director shall determine the effective date of the changes, and shall issue an order, exempt from Sections 5307.3 and 5307.4 and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), informing the public of the changes and their effective date. All orders issued pursuant to this paragraph shall be published on the Internet Web site of the Division of Workers' Compensation.

(3) For the purposes of this subdivision, the following definitions apply:

(A) "Medicare Economic Index" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of a providing physician and other services paid under the resource-based relative value scale.

(B) "Hospital market basket" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient hospital services provided by acute care hospitals that are included in the Medicare prospective payment system.

(C) "Hospital market basket for excluded hospitals" means the input price index used by the federal Centers for Medicare and Medicaid Services to measure changes in the costs of providing inpatient services by hospitals that are excluded from the Medicare prospective payment system.

(h) This section does not prohibit an employer or insurer from contracting with a medical provider for reimbursement rates different from those prescribed in the official medical fee schedule.

(i) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as that term is defined by Section 4620.

(j) The following Medicare payment system components shall not become part of the official medical fee schedule until January 1, 2005:

(1) Inpatient skilled nursing facility care.

(2) Home health agency services.

(3) Inpatient services furnished by hospitals that are exempt from the prospective payment system for general acute care hospitals.

(4) Outpatient renal dialysis services.

(k) Notwithstanding subdivision (a), for the calendar years 2004 and 2005, the existing official medical fee schedule rates for physician services shall remain in effect, but these rates shall be reduced by 5 percent. The administrative director may reduce fees of individual procedures by different amounts, but shall not reduce the fee for a procedure that is currently reimbursed at a rate at or below the Medicare rate for the same procedure.

(*l*) (1) Notwithstanding subdivision (a), the administrative director shall, by January 1, 2013, adopt an official medical fee schedule for physician services that is based on the resource-based relative value scale. The initial resource-based relative value scale official medical fee schedule for physician services adopted under this subdivision shall use a conversion factor, or set of conversion factors, that is determined by the administrative director to result in no overall increased costs to the workers' compensation system as compared to the prior year's official medical fee schedule. The administrative director may adopt multiple conversion factors in the initial fee schedule required by this paragraph over a three-year period to account for the impact of the initial fee schedule on providers. The administrative director may, no less frequently than biennially, revise the official medical fee schedule for physician services based on the resource-based relative value scale.

(2) For purposes of this subdivision, "resource-based relative value scale" means the relative value scale created by the federal Centers for Medicare and Medicaid Services and set forth in the Federal Register for each calendar year.

SEC. 4. Section 3.5 of this bill incorporates amendments to Section 5307.1 of the Labor Code proposed by both this bill and Assembly Bill 378. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2012, (2) each bill amends Section 5307.1 of the Labor Code, and (3)

this bill is enacted after Assembly Bill 378, in which case Section 3 of this bill shall not become operative.

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